Mid and South Essex NHS Foundation Trust

H.M Coroner's Office
Ms Rebecca Mundy
SEAX House
Victoria Road South
Chelmsford
Essex
CM1 1QH

Our Ref: [redacted]

[redacted]

25 April 2024

Dear Ms Mundy

Regulation 28 Report to Prevent Future Deaths- Chloe Anne Tapp

I write further to your Regulation 28 Report to Prevent Future Deaths (PFDR) dated 28 February 2024, relating to the Inquest of Ms Chloe Anne Tapp.

I have carefully reviewed your report and discussed your concerns with my colleagues in the related specialties. I have set out below our response to each concern raised.

Concern One

Neurology departments are so overwhelmed and/or understaffed that a vulnerable young girl (particularly so during the Covid-19 pandemic), was not referred in a timely manner to adult neurology services and in fact, it transpired a referral had not been made at all. This appears to have been done for the first time in August 2021.

We acknowledge your concern that there was a delay in Chloe's referral to adult neurology services, however this delay was not attributable to Mid and South Essex Hospital NHS Foundation Trust.
Chloe was known to our paediatric services however, once she reached 16 years of age her epilepsy was managed by the Royal London Hospital in conjunction with her GP; we did not receive any communication from them relating to her transitional care.

Concern Two

An initial consultation with a complex non-verbal patient was arranged over the telephone, notwithstanding the concerns about a tremor which would have required visual assessment.

We agree that a telephone appointment was not appropriate to fully assess Chloe's clinical presentation on this occasion. However, at that time we were operating clinics differently to manage the significant risks presented by the COVID-19 pandemic.

Patients such as Chloe were risk assessed prior to clinic sessions, and it was considered safer for Chloe to attend a telephone appointment to avoid the risk of contracting COVID-19 or another infection by attending clinic in person. Chloe was considered clinically vulnerable, and we were concerned that if she contracted such an infection, it could be life threatening. I can assure you that we do not routinely operate telephone clinics for patients such as Chloe now.

Concern Three

An overworked consultant under considerable pressure, did not have time before or during the consultation to establish the dose that Chloe was taking and/or apply the appropriate conversion factor, for medications that can interact negatively at higher doses.

Chloe's then current dose was readily available to the Consultant prior to her appointment, it was listed on the second page of the GP letter 10 August 2021. We have reviewed the clinic that took place on 3 September 2021 and can confirm that prior to Chloe's appointment there was one unfilled clinical slot. This is a slot we plan to keep free for urgent/ unexpected cases; and there was one further patient who did not attend. We therefore consider the consultant had time to establish Chloe's current dose prior to the consultation.

Our consultants are also supported by the pharmacy team who are available 24/7 to assist with dosage conversion queries and ad hoc queries. They also have access to online support and resources. Unfortunately, the consultant did not access this support.

Concern Four

No note was made of the tapering regime for the medication change in Chloe's notes.

It is our usual practice to record tapering regimes in patient notes, and this is the expected standard as set out in our clinical record keeping standards policy. The regime was recorded in the letter to Chloe's GP dated 8 September 2021, however the related table drawn up by the Consultant should have been included in Chloe's notes.

Following the medication incident, an urgent communication was sent to all staff in the specialist medicine division setting out the expectation for all regimes to be written in the notes and scanned on to the electronic patient record.

A corporate neurology action plan is in place to make service improvements and increase compliance with record keeping standards.

To ensure adherence to the expected standards we have completed an audit of neurology clinic records during February and March 2024.The results of this audit showed overall good compliance with dictation, headers, footers, and onward referrals. Small deviations that were picked up were fed back to the team and actioned. Audit reviews will continue quarterly to provide assurance to the divisional governance meeting. These are in addition to the Trust wide record keeping audits.

Concerns Five and six

A handwritten note of a tapering regime based on incorrect doses was sent to Chloe. The same regime was repeated in a letter to the Epilepsy Nurses, but this letter was not received until October 2021 (in paper form) as the initial email was sent to an address that no longer existed.

The tapering regime should have been typed, and this is our expected practice. Our action plan (attached) sets out the steps we have taken to make sure staff are aware of this and we are monitoring compliance with this standard via regular audits.

Regrettably when we wrote to the Epilepsy Nurses on 8 September 2021, we were not aware that their office had relocated and therefore the address we wrote to was incorrect. Our letter was subsequently forwarded on in NELFT itself and uploaded onto system 1 on 1 October 2021. The email addresses used were also recorded incorrectly which led to the error and reliance on the postal version for the sharing of information.

We recognise we must do better, and Chloe's case brought about immediate changes to how we communicate with the Epilepsy nurses. The Epilepsy Nurses now have a shared email account that we write to, and we are now communicating with each other effectively. There have been no reported incidents of delayed correspondence since Chloe's case.

Concerns eight, nine and ten

The consultant in question gave evidence of a very bleak picture of ongoing practice in the neurology department; a letter from all four consultants in that department had been sent to the Trust in July 2023, where patient care was described as 'sub-optimal', and numerous concerns were set out including:

- **Chronic staff shortages in respect of doctors, nurses and administrative staff within the neurology department**
- **Substantial and unsafe backlogs for first and follow up appointments**
- **Inability to answer, in a timely manner, the volume of phone calls, phone messages and emails from patients/carers raising queries.**
- **The delays / ways in which investigations are carried out and reported, and the way in which clinical staff can access results.**

A further letter was sent by Chloe's consultant in January 2024 in lieu of her attending a meeting where progress was to be discussed. That letter highlighted that, not only did the concerns remain live, she believed that the department had now reached levels of 'unsafe practice'. The state of the department, compared to when Chloe died was described as 'worse'.

The matters raised in the Consultant's letter in July 2023 were of great concern. I am aware my colleague Dr David Walker, Chief Medical Officer, wrote to you at the time to confirm the action we were taking to ensure the service was safe, a copy of his letter is attached. Our Serious Incident investigation went on to investigate these concerns, and those findings have informed the detailed action plan attached.

In addition to this, we have invested in staffing within the neurology service. Our medical staffing is now fully established which includes four consultants and three specialty doctors. Our medical staffing is reviewed annually to check the needs of the service are properly met.

We now have two nursing posts within the team, both roles have recently been appointed to. Our overall administrative support has also increased and additional funding for administrative staff has been obtained for our Multiple Sclerosis service that sits under the Neurology umbrella.

I am assured that the concerns raised have been fully addressed and the neurology staffing establishment is appropriate to meet the service need.

Concern eleven

Notwithstanding Chloe's death in 2021, the letter in July 2023 and follow-up in January 2024, many of the more significant actions identified remained as part of an Action Plan. Business cases were being drawn up for a number of areas (but not additional consultants) and these had not yet been approved, nor was it guaranteed that they would be.

Prior to the Inquest investigation we had not identified a medication error in Chloe's care. As soon as this was discovered we raised an incident on 21 February 2023 and commenced an internal investigation.

The letter of concern from Chloe's consultant was shared with the Trust in July 2023. The formal Serious Incident process began on 1 March 2023 date and the actions arising from the Incident remain in progress.

Once the issues were identified we took immediate action to ensure the neurology service was safe, and through our Serious Incident investigation we have made significant improvements to the service overall.

An update on our action plan is attached for assurance. Our action plan is extensive, and in places it is a health and care system-wide approach for improvement which regrettably adds a complexity to its completion as multiple partners are involved. I understand the concern that business cases were uncertain at the time of the Inquest hearing, however we have made significant progress with these, and I can assure you that the progress is regularly monitored at a senior level. Before closing any actions, we want to be absolutely assured of their completion and certain that the improvements have been sustained. We would be happy to provide a further update to you once all actions are closed.

Concern Twelve

The independent consultant neurologist in giving evidence expressed that this was not an unfamiliar picture across a number of different Trusts and that there was a recognised shortage of neurologists and increase in demand for that specialty nationally.

On receipt of your PFDR report we reached out NHS England to enquire if this concern had been identified at a national level. We are sighted to the letter addressed to you from Professor Sir Stephen Powis, National Medical Director, of 11 April 2024.

We are also pleased to hear that NHS England are in the process of developing national guidance to support us in our delivery of integrated care services, including neurology. This coupled with our investment in the service should deliver immense improvements across the service, including transition.

We welcome the opportunity to share the improvements we have made with the 'Getting It Right First Time' team and of course, if there are any concerns raised following their visit, we will engage with them and take the required action.

We appreciate the opportunity to learn from these events and we are committed to improve the experience of our patients. We hope that the action we have taken, and will continue to take, has provided assurance that your concerns are being addressed.

If you have any further concerns or you would like to discuss this case further, please do not hesitate to contact me.

Mid and South Essex NHS Foundation Trust

Yours sincerely

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[redacted]
Chief Executive
Mid and South Essex NHS Foundation Trust

Enc.
Action Plan 10.04.2024 v.3.4
Letter from [redacted]02.03.2023